

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Falcon Heights Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1795 Monterey Rd Colorado Springs, CO 80910	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0555</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to choose his or her attending physician.</p> <p>38185</p> <p>Based on interviews and record review, the facility failed to ensure residents on five of five hallways had the right to choose his or her own attending physician.</p> <p>Specifically, the facility failed to allow residents to choose their primary care provider (PCP) when the facility changed medical provider groups.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Choice of Attending Physician policy, reviewed February 2021, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:44 p.m. It revealed in pertinent part, The resident has the right to choose his or her own attending physician.</p> <p>The resident is informed in writing of the name and contact information for his or her attending physician: during the admission process; any time the information changes; and upon the resident/representative's request.</p> <p>II. Resident and resident representative interviews</p> <p>The following residents, who were deemed to be cognitively intact based on facility assessment were interviewed and said the following:</p> <p>Resident #51 was interviewed on 7/29/24 at 10:11 a.m. Resident #51 said he had no idea his physician had been changed. He said the facility did not inform him nor obtain his permission.</p> <p>Resident #40 was interviewed on 7/29/24 at 10:19 a.m. Resident #40 said the facility staff never informed him that his physician had changed. He said a physician entered his room and told him that she was his new doctor. He said he told her he had not changed physicians and she responded that the facility had made the decision and he did not have a choice.</p> <p>Resident #40 said he was very upset that he was not given the choice for his medical provider and the facility had made the change without obtaining his consent.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0555</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #35 was interviewed on 7/29/24 at 10:56 a.m. Resident #35 said the facility did not inform her she was receiving a new physician nor obtain her consent. She said the facility just did whatever they wanted.</p> <p>Resident #21 was interviewed on 7/29/24 at 10:57 a.m. Resident #21 said the facility did not inform her about changing physicians nor obtain her consent.</p> <p>Resident #66 was interviewed on 7/29/24 at 11:13 a.m. Resident #66 said the facility did not ask her permission to change her physician. She said the facility never even informed her. She said the physician walked into her room one day and said she was her new doctor.</p> <p>Resident #2 was interviewed on 7/29/24 at 11:18 a.m. Resident #2 said the facility did not obtain her consent to change physicians. She said she was not informed of the change until the physician entered her room to speak with her.</p> <p>Resident #8 was interviewed on 7/29/24 at 12:14 p.m. Resident #8 said the facility did not inform him nor obtain his consent to change his physician.</p> <p>Resident #75's representative was interviewed on 7/29/24 at 12:30 p.m. The representative said she was not aware the resident's physician had changed. She said she had not heard from the new physician and the facility did not obtain her consent for the change.</p> <p>III. Group interview</p> <p>The group interview was conducted on 7/30/24 at 10:00 a.m. with Resident #11, #68, #54 and #66, who were identified as alert and oriented through facility and assessment. All of the residents said they had not been informed the facility had changed to a new medical provider group. The residents said they were not informed they would be receiving a new physician nor did the facility ask their permission.</p> <p>IV. Record review</p> <p>-The facility was unable to provide documentation that the residents and their responsible parties had been informed and that residents' permission was obtained to change resident physicians.</p> <p>V. Staff interviews</p> <p>The NHA was interviewed on 7/31/24 at 11:00 a.m. The NHA said the facility had changed their primary medical group on 6/1/24. She said it was a corporate decision and the facility administration was not given a choice. The NHA said she was not sure if residents were informed. She said a meeting was not held with residents, nor was a letter provided to inform them or obtain their consent.</p> <p>The regional clinical consultant (RCC) was interviewed on 7/31/24 at 11:15 a.m. The RCC said the facility was not given a choice when the physician medical group was changed on 6/1/24. She said it was a corporate decision and the residents were not informed nor was their consent obtained.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50315</p> <p>Based on observations, record review and interview, the facility failed provide treatment and services in accordance with professional standards of practice for one (#9) of one resident out of 49 sample residents.</p> <p>Specifically, the facility failed to ensure Resident #9 received quality care when the on-call physician did not return calls upon Resident #9 experiencing a change of condition.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Choice of Attending Physician policy, revised February 2021, was received from the nursing home administrator (NHA) on 7/31/24 at 4:44 p.m. It documented in pertinent part, The attending physician must be monitoring changes in the resident's medical status, providing consultation or treatment when called by the facility, overseeing the plan of care, prescribing an appropriate medical regimen, providing timely information about the resident's condition and medical needs to the resident, representative and interdisciplinary team and visiting the resident at appropriate intervals.</p> <p>II. Resident #9</p> <p>A. Resident status</p> <p>Resident #9, age 77, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (lung disease restricting airflow and breathing problems), pulmonary hypertension (high blood pressure in lungs), dependence on supplemental oxygen, hypertensive heart disease with heart failure (heart failure from high blood pressure) and hypertension (high blood pressure).</p> <p>The 5/21/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required partial assistance with transferring, dressing, toileting and bathing.</p> <p>B. Record review</p> <p>A nurse progress note dated 6/4/24 at 5:16 p.m. documented Resident 9's condition had changed and was deteriorating. It read that the resident continued to have a non-productive cough, which caused the resident to gag. PO2 (partial oxygen pressure) was 90% (percent) on 3 liters per minute (lpm) of oxygen. Resident #9's lung sounds had inspiratory and expiratory wheezing (whistling sound caused by narrowing airway). The nurse called the on-call provider two times to discuss the resident's condition. She reached voicemail both times. She left extensive messages to call the nurse back for treatment orders.</p> <p>-The on-call physician never returned the nurses call to provide further instruction of care for Resident #9.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse called the retired medical director due to the on-call physician not calling back after two extensive messages were left. A chest x-ray was ordered by the retired medical director on 6/4/24.</p> <p>Resident #9 went to the emergency roaignom on [DATE] and was discharged back to the facility on [DATE].</p> <p>Documentation from the hospitalization on [DATE] revealed Resident #9 was diagnosed with acute on chronic heart failure (inadequate pumping of blood through heart), pneumonia (infection in the lungs), chronic obstructive pulmonary disease, chronic anemia (low red blood cell production) and renal insufficiency (poor kidney functioning).</p> <p>A physician's note from the retired medical director dated 6/5/24 at 5:46 p.m. read in pertinent part, I asked nursing to call [the resident's primary care physician], to discuss the case with her. Chest x-ray showed findings consistent with congestive heart failure (heart failed to pump blood efficiently). Pneumonia could not be ruled out. I asked nursing to call back if the on-call (physician) did not call back within 1-2 (one to two) hours, as is the standard of care in our community long term care settings. This patient (Resident #9) will need a physician visit this week to ensure that she is improving. That responsibility belongs to [the primary care physician] and her team.</p> <p>A nursing note dated 6/16/24 at 12:56 a.m. documented Resident 9's condition had changed again and continued to deteriorate. It read that the resident's partial oxygen pressure was at 77% (normal is greater than 90%) and she was coughing and having trouble breathing. Resident #9 was sent to the emergency room and arrived back to the facility on [DATE] at 1:49 p.m.</p> <p>A physician's progress note, dated 6/16/24 at 12:18 p.m., was written by Resident #9's primary care physician. The note indicated 6/16/24 was the first time the new physician had seen and evaluated the resident. The note documented Resident #9 was transferring care to (name of provider group) for medical management.</p> <p>III. Staff interviews</p> <p>The director of nursing (DON) was interviewed on 7/31/24 at 11:20 a.m. The DON said the corporation had made a decision to change medical groups at the facility. She said the residents were not informed, nor was their consent obtained.</p> <p>Cross reference F555: the facility failed to inform and obtain consent from the residents and/or their responsible party when the corporation changed primary medical groups.</p> <p>The DON said it took over a month for the new medical group to enter the facility and see residents. She said the new medical group would not return calls to nursing overnight or on the weekends. She said she directed the nurses to contact the retired medical director (RMD) to receive care instructions if they had not received a call back within 15 minutes. She said she was frustrated and the nurses on the floor were frustrated the new physician group would not return calls after hours. The DON said it had the potential for negative outcomes for residents.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The RMD was interviewed on 7/31/24 at 11:30 a.m. The RMD said the corporation of the facility decided to change primary medical groups in the facility, along with taking over all of his residents without the resident's or their responsible parties' consent.</p> <p>The RMD said the nurse had reached out to him on 6/4/24 for treatment orders for Resident #9 since the on-call physicians did not call her back after leaving multiple messages. He said since Resident #9 was not his patient, he did not feel comfortable treating her over the phone so he sent orders to send her out to the emergency room to get checked out. He said the professional standard of care would be to see a resident within 24 to 48 hours after hospitalization . He said it was his understanding that Resident #9 was not seen for more than 10 days after her initial change of condition on 6/4/24.</p>